Cascadian Plastic Surgery PLLC
Jungwon Genevieve Park, MD, PhD
14 N Mission St Ste 201
Wenatchee, WA 98801
(509) 596-0096

PATIENT NOTICE OF PRIVACY PRACTICES

Cascadian Plastic Surgery PLLC

We are required by applicable federal and state law to maintain the privacy of your health information, which includes your name, date of birth, address, and other identifying information. We are also required to give you this Notice about our privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "Medical Information"). We must follow the privacy practices that are described in this Notice which may be amended from time to time).

For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures *Without* Your Written Authorization: We do not need any type of authorization from you for the following uses and disclosures (the examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law):

1. Treatment: We may use and disclose your Medical Information in order to provide treatment to you. For example, we may use Medical Information to diagnose and provide medical services to you. In addition, we may disclose Medical Information to other health care providers involved in your treatment.
2. Payment: We may use and disclose your Medical Information for payment activities. For example, we may use and disclose your Medical Information so that services you receive are appropriately billed to, and payment collected from, your insurer, or to permit your health insurer to take certain actions before it approves or pays for treatment services. However, you may ask Cascadian Plastic Surgery not to share your Medical Information with your insurer under the The Health Information Technology for Economic and Clinical Health (HITECH) Act.
3. Health Care Operations: We may use and disclose your Medical Information in connection with our health care operations, including training programs, accreditation, certification, licensing, or credentialing activities. We may also provide Medical Information

to our accountants, lawyers, consultants and others for operational purposes.

4. Other Uses and Disclosures Required or Permitted by Law: We may use and disclose your Medical Information when we are otherwise required or permitted to do so by law. For example, we may disclose Medical Information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence of the possible victim of other crimes. In addition, we may disclose Medical Information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: Disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access Medical Information; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions as otherwise authorized by law.

B. Uses and Disclosures When You Have the Opportunity to Object
    1. Family and Other Persons Involved in Your Care. We may disclose your Medical Information to your family members or friends who are involved in assisting with your health care. If you are present, then we will provide you with an opportunity to object prior to such disclosure. If you are unable to either agree or object to such a disclosure, we may disclose your Medical Information to such person(s) if they are your designated Power of Attorney or your next of kin.
    2. Disaster Relief Efforts. We may use or disclose Medical Information to a public or private entity authorized by law or its charter to assist in disaster relief efforts for the purpose of coordinating notification of family members of your location, general condition, or death.

C. Uses and Disclosures that Require Your Written Authorization. Uses and disclosures other than those described in Section IA and B above will only

be made with your written authorization. For example, you will need to sign an authorization form before we can send Medical Information to your life insurance company or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Rights to Inspect and Copy: You may request access to your medical record and billing records maintained by use in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the costs of copying and sending you any records requested.

B. Right to Alternative Communications: You may request, and we will accommodate, any reasonable written request for you to receive Medical Information by alternative means of communication or at alternative locations.

C. Right to Request Restrictions: You have the right to request a restriction on Medical Information we use or disclose for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Practice Administrator as indicated below. We are not required to agree to any such restriction you may request.

D. Right to Accounting of Disclosures: Upon written request, you may obtain an accounting of certain disclosures of Medical Information made by us in the last six years. This right applies to disclosures for purposes other than treatment, payment, or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. Right to Request Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

F. Right to Obtain Notice: You have the right to obtain a paper copy of this Notice at any time by submitting a request to info@cascadianplasticsurgery.com.

G. Right to Receive Notification of a Breach: We are required to notify you of any breach of your secured Medical Information according to the

requirements under federal law. This notification will be provided to you in writing.

H. Questions or Complaints: If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may contact us at info@cascadianplasticsurgery.com <mailto:info@cascadianplasticsurgery.com>, 14 N Mission St Ste 201, Wenatchee, WA 98801. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or with our office.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date: This Notice is effective on 1/1/2026.

B. Changes to this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Medical Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice on our web site at <https://cascadianplasticsurgery.com> and in the waiting area of our office. You may also obtain any revised notice by contacting the Practice Manager via telephone at 509-596-0096 via mail at 14 N Mission St Ste 201, Wenatchee, WA 98801 or via email at info@cascadianplasticsurgery.com.

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IV. TYPES OF COMMUNICATION: Phone, secure portal messaging, physical mail, and fax are generally accepted methods of secure communication. There are other additional types of communication that we can use with your permission.

A. I ACCEPT THE FOLLOWING ADDITIONAL TYPES OF COMMUNICATION REGARDING MY PERSONAL MEDICAL INFORMATION:

☐ Voicemail on the phone number on file, or provided by referring office

☐ Email to address on file

☐ Text messaging to mobile phone on file

By my signature below, I, _____, acknowledge that I have been provided with the Notice of Privacy Practices for Cascadian Plastic Surgery PLLC.

_____ _____

Patient Signature Date